# MEDICAL HISTORY FORM

Name: ________________________________________ Today's Date: ___________________

Date of Birth: __________________ Provider: ____________________

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Have you ever had any of the medical problems listed below? For any "yes" answers **please circle and give details**:

Diabetes
High Blood Pressure
Stroke
High Cholesterol
Heart Problems
Hepatitis (A, B, or C)
Gallstones
Kidney Stones
Kidney Infections
Seizures
Migraine headache with aura
Migraines headache without aura
Thyroid Problems
Abnormal mammogram
Breast biopsy
Osteopenia or osteoporosis
Cancer Type(s): ________________________
Blood Clots in your legs or lungs
Asthma
Pneumonia
Tuberculosis
Depression
Anxiety
Eating Disorder
Bipolar Disorder
Alcoholism
Drug Use
Blood Transfusions
Anemia
Gastrointestinal Problems
Victim of Domestic Violence
Victim of Sexual Abuse

Please list any operations or hospitalizations you have had in your lifetime:

| **Date** | **Type of Operation or Reason for Hospitalization** | **Details / Comments** |
|---|---|---|
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What is the name of your family doctor, internist, or PCP? ____________________________________

## MEDICAL HISTORY FORM

List any medications or substances you are allergic to, and what reaction each one caused, (e.g. "rash"):

______________________________________________________________________________
______________________________________________________________________________

List any medication, (prescriptions or over-the-counter), including vitamins and supplements you are taking now:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Health Maintenance:**

| | | |
|---|---|---|
| Date of last Pap Smear: | Results: | Location/Provider: |
| Date of last Mammogram: | Results: | Location/Provider: |
| Date of last Bone Density Study: | Results: | Location/Provider: |
| Date of last Colonoscopy: | Results: | Location/Provider: |
| Screening Lab Work: | Abnormal results: | |
| Circle any vaccines you have received and provide year given:<br>Flu vaccine / Shingles / Tdap / Gardasil | | |

**Family History:**

Please list any health problems in member of your immediate family:

Mother: ____________________________________________________________________
Father: ____________________________________________________________________
Sister(s): __________________________________________________________________
Brother(s): _________________________________________________________________
Children: __________________________________________________________________

In your more extended family (aunts/uncles, grand-parents), has anyone had any of the following cancers?
If so, how are they related to you (e.g. grandmother on my dad's side)?

Breast cancer: ______________________________________________________________
Ovarian cancer: _____________________________________________________________
Colon cancer: _______________________________________________________________

Do either of your parents have osteoporosis? __________________________________
Has either your mom or dad ever had a broken hip? _____________________________

# MEDICAL HISTORY FORM

**Gynecologic History:**

Have you ever had any of these female problems? Please **circle and give details** for any "yes" answers:

Fibroids
Endometriosis
Ovarian cysts
Infertility
Polycystic Ovary Syndrome (PCOS)
Urinary incontinence
Heavy, prolonged, or irregular menstrual bleeding
Pelvic pain
PMS
Breast problems or breast biopsies

Have you ever had an abnormal pap? Yes / No When? ____________________
Did you ever receive treatment for this? Yes / No
If "yes" what treatment was done? (freezing, laser, LEEP, cone biopsy)
Did you Paps go back to normal after the treatment? Yes / No

Are you currently sexually active? Yes / No
Have you had more than one sex partner in the past year? Yes / No

Are you using contraception? Yes / No
If "yes" which method? (circle on list below.)

Birth control pills – which brand? ______________________________________________________________
Birth control patch (Ortho Evra)
Birth control ring (NuvaRing)
Birth control shot (Depo-Provera)
LNG-IUD (Mirena/Kyleena/Skyla/Lyletta) – When was it inserted? ________________________________
Paragard IUD (copper) – When was it inserted? ____________________________________________
Nexplanon – When was it inserted? ____________________________________________________________
Condoms
Diaphragm
Tubal ligation
Essure
Partner has vasectomy
Natural family planning

# MEDICAL HISTORY FORM

Have you ever had any of these infections?   Yes / NO (circle any that apply and indicate when):

Chlamydia
Gonorrhea
Syphilis
HIV
HPV (Human Papilloma Virus)
Genital Herpes
Genital Warts
PID (Pelvic Inflammatory Disease or "tubal infection")

**Menstrual History**:

How old were you when you had your first period? ____________________________________________

Describe your menstrual cycles (e.g. "about ever 30 days, 5 days long, with 2 days heavy and the rest light, mild cramps on heavy days):

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

If you are in menopause, at what age did your periods stop? ______________________________
Are you having hot flashes or night sweats?  None / mild / moderate / severe (circle one)
Did you have hormone replacement therapy?   Yes / No
Are you having problems with vaginal dryness?   Yes / No   Painful intercourse?   Yes / No

**Obstetric History:**

Please fill in details of any deliveries:

| Date | Type of Delivery (vaginal or c-section) | Baby's weight | Gender | Name | Complications/Comments |
|---|---|---|---|---|---|
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Any miscarriages? ____________   Abortions? _________________   Tubal Pregnancies? __________

# MEDICAL HISTORY FORM

**Social History:**

What is your occupation? ________________________________________

Marital Status (circle one): Single Married Divorced Widowed Separated Engaged

Name of spouse: __________________________________________________

Tobacco use? Yes / No How many cigarettes per day? _____________

How many alcoholic beverages do you drink per week? ___________________

Use of street drugs? Yes / No What types(s)? _______________________

Seat belt use? (circle one) Always / Usually / Seldom / Never

How many times a week do you exercise? _________________________________________________

Do you usually wear sunscreen when spending time outside? Yes / No

Do you feel safe at home? Yes / No If the answer is "no" please explain why not: ___________

_____________________________________________________________________________________

_____________________________________________________________________________________